PRINTED: 08/28/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		COMPLETED 07/22/2014			
		150166	B. WIN			07/22/	ZU14	
NAME OF PROVIDER OR SUPPLIER PINNACLE HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 9301 CONNECTICUT DR CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY	ΓE	(X5) COMPLETION DATE	
S000000	REGULATORT OR	LSC IDENTIFTING INFORMATION)		TAG			DATE	
3000000	This visit was for survey. Date of Survey:	r a State licensure 07/21-22/14	S00	0000				
	Facility #: 0066	19						
	Surveyors: ReBecca Lair, Lo Medical Surveyo							
	Jacqueline Brow Public Health Nu							
	Lynnette Smith Laboratorian							
	QA: claughlin 0	7/29/14						
S000362	410 IAC 15-1.4-1 GOVERNING BOA 410 IAC 15-1.4-1((E)(F	d)(6)(A)(B)(C)(D)						
	(d) The governing for assuring that qu is provided. In acc hospital policy, the shall do the followi	cordance with governing board						
	6) Ensure that the following:	hospital does the						
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI		TITLE		(X6) DATE	

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
150166		150166	B. WING		07/22/2014	
NAME OF D	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			9301 (CONNECTICUT DR		
PINNACLE HOSPITAL			CROV	/N POINT, IN 46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	procurement. (C) Inform families persons of potentic donors of the optic admission or at the potential donor. (D) Use discretion contacts with potentials. (E) Notify the approgranization of podonors.	organ and tissue elicies and e facilitation of donations, including s or authorized al organ and tissue on of donation on e time of death of a and sensitivity in ential organ donor ropriate procurement tential organ abership in the organ transplantation				
	interview, the fa appropriate orga organization, per deaths. Thus the facility procurement orgogan donors. Findings: 1. Review of the hospital and the Tissue Donor No.	r contract, of all hospital	S000362	Responsible person: CNO/CO 1. Steps Taken: o Education given to entire staff on in-patie unit. The education included: Process to follow upon death opatient Call Gift of Hope Fill out Gift of Hope form Place completed form in the patient chart Document death in the "death log book" (kept on in-patient) Place chart in the CNO/COO mailbook Prevention Plan o The CNO/COO will review every dochart to ensure completeness and accuracy of Gift of Hope forms. o The CNO/COO will review the death log (from Medical Records) monthly. The	ent 	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	DING 00		COMPLETED	
		150166	B. WING			07/22/	2014
				EET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					NNECTICUT DR		
PINNACL	E HOSPITAL				POINT, IN 46307		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	j	DEFICIENCY)		DATE
	Gift of Hope of a	all individuals who have			will be compared to "death log		
	died or death is i	mminent".		book." o The CNO/COO will compare the quarterly reports			
				from Gift of Hope with death lo	,		
	2. Donation Act	ivity Report 2013			report from Medical Records to	~	
	indicated the hos			ensure completeness. o			
	Hope of 12 death	-			Education regarding the Gift of	:	
	Register January				Hope process will be given		
		ol report indicated 13			quarterly to nursing staff and ir		
		•			orientation to all new nursing staff.		
		in 2013 and 12 deaths			Stail.		
	were reported to Gift of Hope. Thus the hospital failed to show evidence that all						
	deaths were repo	orted.					
	3. Interview wit	th Employee #A1 on July					
		verified the above					
	information.						
0000050	410 IAC 15-1.5-6 NURSING SERVICE						
S000952							
	410 IAC 15-1.5-6(
	1.0	,					
	(d) Blood transfusi	ons and intravenous					
	medications shall l						
		tate law and approved					
		ies and procedures.					
	If the blood transfu intravenous medic						
		ersonnel other than					
	physicians, the pe						
	special training for	these procedures					
	in accordance with						
	Based on review	of policies and	S000952	:	For Item 2a. Responsible		07/24/2014
	procedures, patie	ent records, validated			person: CNO/COO 1. Steps	8	
	cooler logs, and	staff interview, the			Taken: o Education given to entire staff on in-patient unit. T	his	
	nursing service f	ailed to ensure blood			education will be given to the	5	
					3. 3. 3. 3. 3. 4. 5. 4. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		150166	B. WIN			07/22/2014	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ONNECTICUT DR		
PINNACLE HOSPITAL					N POINT, IN 46307		
FINNACI	LETIOSFITAL			CROW	V FOINT, IN 40307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	transfusions wer	e administered in			nursing staff quarterly and in		
	accordance with	approved medical staff			general orientation. The		
	procedures for 9	(Patient #L1-L9) of 9			education included: - Blood		
	patient records re	· ·		Transfusion policy Review of	OΤ		
	patient records i	eviewed.			timelines for initial and reassessment of vitals (initiation	nn.	
					during, and completion) - Afte		
	Findings include	:			each blood transfusion, the	•	
					patient record will be reviewed	by	
	1. Review of po	licies / procedures on			the RN transfusing the blood a		
	7-22-14 between	n 9:00 AM and 9:50 AM			the shift charge nurse to ensur		
	revealed a nolicy	y / procedure titled:			accuracy of each entry and		
	1	•			compliance with the policy. 2	<u>.</u> .	
	"Blood, Blood Products, Derivatives Administration," policy number				Prevention Plan o		
					Compliance will be monitored	by	
	PCS-18," last re	eviewed "February			having the patient record		
	2013," which rea	ad: "Blood transfusion			reviewed by the RN transfusin	g	
	must be initiated	within thirty (30)			the blood and the shift charge	ach	
		e time the bag is removed			nurse to ensure accuracy of ea entry. o All blood transfusion	aCII	
		cooler." and "Reassess			forms will be monitored		
					for compliance and accuracy b)V	
	Vitals (T, P, ans				the CNO/COO and the charge		
	Completion (sic)) of Transfusion (sic)"			nurse. For Item 2b.		
					Responsible person: CNO/CC	00	
	2. Review of pa	tient records on 7-22-14			 Steps Taken: o The 		
	between 9:50 Al	M and 11:00 AM and			following statement was added		
	review of valida	ted cooler logs on			the Temperature monitor form		
		12:45 PM and 12:50			7/24/2014 Removal of bl	ood	
					product from cooler will be documented including date, tir	ne	
	PM indicated the following: a. Patient #L6 had a blood transfusion				and initials of RN removing the		
					unit. o Education of the	•	
		14. The time the			addition was given to entire sta	aff	
	transfusion was	started was not			on in-patient unit. This educati		
	documented. The time the transfusion was discontinued was "1600" and the "Post Transfusion" vital signs were				will be given quarterly to the		
					nursing staff and at general		
					orientation to all new nurses.	2.	
		1555," 5 minutes before			Prevention Plan o Compliano		
					will be monitored by having the		
		vas discontinued.			patient record reviewed by the		
	b. It was unab	le to be determined if the			transfusing the blood and the	oillit	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2014				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 9301 CONNECTICUT DR				
PINNACLE HOSPITAL			CROW	CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
TAG	transfusions we minutes from to removed from because time the removed from documented or record or valid following paties. Patient # D L1 L2 L3 L4 L5 L6 L7 L8 L9 3. In interview 12:45 PM and #L21 acknowled documentation	he time the bag was the validated cooler ne unit of blood was the cooler was not in the blood administration ated cooler logs for the ents: Pate of Transfusion 7-18-14 5-8-14 5-16-14 4-17-13 5-8-14 5-9-14 4-15-14 5-13-14 5-21-14 7 on 7-22-14 between 12:50 PM, Staff Member edged that there was no to determine when the were removed from the	TAG	charge nurse to ensure accura of each entry. o All blood coot temperature logs will be monitored for compliance and accuracy by the CNO/COO ar charge nurse.	acy DATE			

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